Charles County Commissioners
Standard Over 65 with Major Medical

Coverage Period: 07/01/2020 – 06/30/2021
Coverage for: Individual | **Plan Type:** TRAD

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can see the Glossary at www.carefirst.com/sbcg or call 1-855-258-6518 to request a copy. For more information about your coverage, or to get a copy of the complete terms of coverage, please visit www.carefirst.com.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes, all In-Network services are provided without a deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical: $200 individual Prescription Drug: $6,400 individual	The out-of-pocket limit is the most you could pay in a plan year for covered services. If you have other family member(s) on the plan, each family member may need to meet their own out-of-pocket limits, OR all family members may combine to meet the overall family out-of-pocket limit, depending upon plan coverage. Please refer to your contract for further details.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, copayments for certain services, and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.carefirst.com or call 855-258-6518 for a list of Network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Covered under Major Medical	20% of Allowed Benefit	None
	Specialist visit	Covered under Major Medical	20% of Allowed Benefit	None
	Retail health clinic	Covered under Major Medical	20% of Allowed Benefit	None
	Preventive care/screening/ immunization	No Charge	20% of Allowed Benefit	Some services may have limitations or exclusions based on your contract
If you have a test	Diagnostic test (x-ray, blood work)	Covered under Major Medical	20% of Medicare Part B deductible and Allowed Benefit	None
	Imaging (CT/PET scans, MRIs)	Covered under Major Medical	20% of Medicare Part B deductible and Allowed Benefit	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com/rxgroup	Generic drugs	$5 copay	Paid As In-Network	For all prescription drugs: Prior authorization may be required for certain drugs; No Charge for preventive drugs or contraceptives; Copay applies to up to 34-day supply; Up to 90-day supply of maintenance drugs is 2 copays; at mail or CVS Retail; 3 copays at all other retail stores." Specialty Drugs: Participating Providers: covered when purchased through the Exclusive Specialty Pharmacy Network Non-Participating Providers: Covered under Major Medical
	Preferred brand drugs	$25 copay	Paid As In-Network	
	Non-preferred brand drugs	$50 copay	Paid As In-Network	
	Preferred Specialty drugs	$5/$25/$50 copay	Not Covered	
	Non-preferred Specialty drugs	$5/$25/$50 copay	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	20% of Medicare Part B deductible and Allowed Benefit	None
	Physician/surgeon fees	No Charge	20% of Medicare Part B deductible and Allowed Benefit	None
If you need immediate medical attention	Emergency room care	No Charge	20% of Medicare Part B deductible and Allowed Benefit	Limited to Emergency Services or unexpected, urgently required services; Additional professional charges may apply

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	Covered under Major Medical	20% of Medicare Part B Allowed Benefit	None
	Urgent care	Covered under Major Medical	20% of Medicare Part B deductible and Allowed Benefit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Prior authorization is required
	Physician/surgeon fees	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Covered under Major Medical	20% of Medicare Part B deductible and Allowed Benefit	None
	Inpatient services	No Charge	Not Covered	Prior authorization is required; Additional professional charges may apply
If you are pregnant	Office visits	No Charge	No Charge	For routine pre/postnatal office visits only. For non-routine obstetrical care or complications of pregnancy, cost sharing may apply.
	Childbirth/delivery professional services	No Charge	Not Covered	None
	Childbirth/delivery facility services	No Charge	Not Covered	Additional professional charges may apply
If you need help recovering or have other special health needs	Home health care	No Charge	20% of Medicare Part A/Part B Allowed Benefit	Prior authorization is required. Benefits are limited to 40 Home Health care visits per benefit period. Benefits are limited to 90 Home Health care visits per episode of care.
	Rehabilitation services	Covered under Major Medical	20% of Medicare Part B deductible and Allowed Benefit	Benefits are limited to 100 combined visits with Physical, Speech and Occupational Therapies
	Habilitation services	Covered under Major Medical	20% of Medicare Part B deductible and Allowed Benefit	Prior authorization is required after the first visit Benefits are limited to Members under the age of 19
	Skilled nursing care	21st to, and including, the 100th day: No Charge	Thereafter: 20% of Allowed Benefit	Prior authorization is required
	Durable medical equipment	Covered under Major Medical	20% of Medicare Part B Allowed Benefit	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	No Charge	20% of Medicare Part A Allowed Benefit	Prior authorization is required There must be a willing and able Caregiver available. Respite Care is limited to a maximum of fourteen (14) days per Benefit Period. At the discretion of CareFirst, Respite Care may be limited to five (5) consecutive days for each inpatient stay. Bereavement counseling is limited to the six (6) month period following the Member's death or fifteen (15) visits, whichever occurs first.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Routine eye care
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Acupuncture
- Bariatric surgery
- Chiropractic care
- Coverage provided outside the US. See www.carefirst.com
- Hearing aids
- Infertility treatment
- Non-emergency care when travelling outside the US
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor Employee Benefits Security Administration, http://www.dol.gov/ebsa/healthreform, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, http://www.cciio.cms.gov, or call 1-877-267-2323 x61565. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor Employee Benefits Security Administration, http://www.dol.gov/ebsa/healthreform, or call 1-866-444-EBSA (3272); or

Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, http://www.cciio.cms.gov, or call 1-877-267-2323 x61565.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al 1-855-258-6518.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-6518.]
[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-855-258-6518.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-258-6518.]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$0**
Specialist	**$0**
Hospital (facility)	**$0**
Other	**$0**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,280
The total Peg would pay is	**$1,320**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$0**
Specialist	**$0**
Hospital (facility)	**$0**
Other	**$0**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$215
Coinsurance	$0
What isn't covered	
Limits or exclusions	$2,590
The total Joe would pay is	**$2,805**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$0**
Specialist	**$0**
Hospital (facility)	**$0**
Other	**$0**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,900
The total Mia would pay is	**$1,900**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.